From:

Completed by:

Date:

CURE - TB
Binational Tuberculosis Referral Form

To: CURE-TB PROGRAM
P.O. Box 85222 MS P511D
San Diego, CA 92186-5222
Fax: (619) 692-8020
Tel (619) 542-4011 or (619) 542-4015

Patient Name:_____
Last Name (paternal), Last Name (maternal), First Name

Sex: ❒ Male ❒ Female **Date of Birth**:_____

Case Status: ❒ Verified ❒ Suspect

Major Site of Disease: ❒ Pulmonary ❒ Other:_____

Type of Referral Service:
❒ Case referral
❒ Contact Investigation (Specify in Remarks)
❒ Request for Information (Specify in Remarks)
❒ Other (Specify):_____

Patient Address in Mexico:

_____
Street, Num., (Neighborhood: i.e. Fraccionamiento, Colonia, Sección)

_____
City, State, Zip Code

Telephone:_____

Telephone Location:_____
Patient's House, Relative's House, Other (Specify)

Health Provider in Mexico:
Name:_____ Telephone:_____

Patient Address in U.S. or Emergency Contact in the U.S.:

_____
Num., Street, Apt. #

_____
City, State, Zip Code

Telephone:_____

Telephone Location:_____
Patient's House, Relative's House, Other (Specify)

Health Provider in U.S.
Name:_____ Telephone:_____

Clinical Information

Bacteriology					Chest X-Ray		Skin Test Results	
Date	**Specimen Type**	**Smear**	**Culture**	**Susceptibility**	**Date**	**Results**	**Date**	**mm**

BCG History: ❒ Yes, Year_____ ❒No ❒ Unknown

Symptoms: ❒ Cough ❒ Hemoptysis ❒ Fever ❒ Weight Loss ❒ Night Sweats ❒ Other:_____

Medications

	Dose/ Frequency	Date started	Date stopped
INH			
PZA			
RIF			
EMB			
Rifamate			
Rifater			

Planned Date of Completion:

Reported as verified case? ❒ Yes ❒ No
If yes, state where RVCT submitted:_____
Year RVCT reported:_____ RVCT #:_____

Remarks:_____

Optional

Country of Origin:_____
State of Origin if from Mexico:_____
Mex. State of Residence prior to U.S. arrival:_____
Year of Arrival to U.S. :_____

Current Occupation:_____
Frequency of Travel to Mexico:
❒ Daily ❒ Monthly ❒ Once Every Few Years
❒ Weekly ❒ Once a Year ❒ Other:_____

Instructions for Completion:

1. **From** box: Complete name, phone number, addresses, and date referral initiated.

2. **Patient Name** box: Hispanic individuals often use both maternal and paternal last names. When completing patient name it is important to indicate both last names if this information is available.

3. **Patient Address in Mexico** box: Be specific and detailed regarding patient address. Include the colonia (neighborhood), as well as the street address.

4. **Patient Address in US** box: Complete as fully as possible.

5. **Clinical Information** box: Complete as fully as possible. If cultures are not final, please forward culture information when final. Clarify susceptibility results and dates of specimen collection. If susceptibilities are not final, please forward information when final. (You may attach lab results directly).

6. **Medications** box: List all TB medications as well as other medications which affect TB treatment.

7. **Country of Origin** box: Optional information. Completion of this information will aid in the compilation of data regarding patterns of movement of TB patients between the US and Mexico.